

FILED MAY 27 1946

Registration District No.

Primary Registration District No. 2000

Registrar's No.

387

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1520 Lilly, Route 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1520 Lilly St.
(If rural, give location)
(e) Citizen of foreign country No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel Henry Gaston

3. (b) If veteran, name war None 3. (c) Social Security No. UNK.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mattie C. Gaston 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased May 11, 1890
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 24 If less than one day hr. _____ min. _____

9. Birthplace Marshfield Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Storekeeper

11. Industry or business Frisco R. R. Co.

MOTHER FATHER { 12. Name Gardner P. Gaston.
13. Birthplace Webster Co., Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Williams,
15. Birthplace Webster Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James Russell Gaston,
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof May 7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cem.

18. (a) Signature of funeral director J. K. Lingner & Co.

(b) Address Springfield Mo.

19. (a) 5-7-46 (b) S. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5, year 1946 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from Mon 1 1945 to May 5 1946, that I last saw him alive on May 4 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) N

Major findings: Of operations 450
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury 0

23. Signature W. Deibel (M. D. or other) _____
Address Springfield, Mo. Date signed May 5, 46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

15193

MAY 29 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Max Rhodes

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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